ASSURANT
Employee
Benefits®

Prepaid Dental

Good news about dental benefits for employees of DEERPARK, CITY OF (PLAN C300)

A Dental Plan Means Healthy Smiles

Because you are a valued employee, we are pleased to offer you the opportunity to enroll in a dental benefit plan provided by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company. This prepaid dental plan offers benefits through a network of Plan Dentists. When you enroll for benefits, treatments you receive from your selected Plan Dentist will be provided at reduced fees called copayments. For your information, a partial list of frequently used dental treatments is included.

Plan Features

- No Deductibles
- No Waiting Periods
- Coverage for Pre-existing Conditions
- No Claim Forms to File for Plan Dentist and Plan Specialty Dentist Services
- No Referrals Required for Specialty Dentist Services
- No Annual Maximum for Plan Dentist and Plan Specialty Dentist Services

Important Enrollment Information

To enroll, just follow three simple steps:

1. Select a general dentist from the Directory of Dentists for yourself and every eligible member of your family. Each family member may choose a different Plan Dentist. You must select a Plan Dentist to receive services. Except for certain Specialty Dentist services, all services must be performed by this selected Plan Dentist. You may change your Plan Dentist(s) throughout the Plan Year in accordance with the provisions of the group agreement. However, all services must be performed by a Plan Provider.
2. Complete the enclosed enrollment form, being sure to include the Dental Facility Number of each Plan Dentist selected.
3. Return your completed enrollment form to your Personnel Department or Benefits Manager authorizing payroll deductions for your coverage.

Finding a Provider

You can find a dental provider in the Heritage Series Provider Network by visiting our web site at www.assurantemployeebenefits.com, clicking on the "Provider Search" link, and then selecting Heritage Series. Availability of Plan Dentists and Plan Specialty Dentists varies depending on location.

If you have any questions, call Customer Service at 800.443.2995.

Benefits are provided by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company. United Dental Care of Texas, Inc. is a Dental HMO (Health Maintenance Organization) or DHMO.

GDSA Form No. BDC-GDSA-TX
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Savings You Can See

Monthly Payroll Deduction†

Employee **$10.74**

Employee + 1 Dependent **$17.29**

Employee + Family **$26.37**

†May be changed according to the terms of the Group Dental Service Agreement. Cost includes the Specialty Benefit.

The following is a list of commonly used dental treatments. It is not the Evidence of Coverage. After you enroll, a complete list of copayments will be provided to you along with your Evidence of Coverage.

Secure Plan

1. Plan Dentist Services

The dental services listed in the following schedule are covered only when provided by the Member's selected Plan Dentist. The Member will be responsible for paying the amount listed in the "Member Copayment" column (plus any applicable lab fees*) at the time the service is received, or in accordance with the selected Plan Dentist's billing procedures. To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Evidence of Coverage. The Plan Dentist is permitted to charge the member for any missed appointments if the Member fails to give at least 24 hours notice. The charge may not exceed $25.00.

Services marked with a single asterisk (*) below also require separate payment of laboratory charges. The laboratory charges must be paid to the Plan Dentist in addition to any applicable copayment for the service.

Payment for each service of a Non-Plan Dentist (at that dentist's normal retail charge) is the responsibility of the Member, except for Plan Benefits for covered dental Emergency Services.

2. Plan Specialty Dentist Services

See the enclosed Specialty Benefit Copayment Schedule.

ADA Code**	Service Description**	Member Copayment
	Appointments	
None	Office visit - during regularly scheduled hours***	10.00
D0120	Periodic oral evaluation - established patient‡ (once in any 6 calendar months)	No Charge
D0140	Limited oral evaluation - problem focused	25.00
D0150	Comprehensive oral evaluation - new or established patient‡ (once in any 6 calendar months)	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	20.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	20.00
D0180	Comprehensive periodontal evaluation - new or established patient	20.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	70.00
D9440	Office visit - after regularly scheduled hours	40.00
	Diagnostic Dentistry	
D0210	Intraoral - complete series (including bitewings)‡ (once in any 3 calendar years)	5.00
D0220	Intraoral - periapical first film	No Charge
D0230	Intraoral - periapical each additional film	No Charge
D0240	Intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0260	Extraoral - each additional film	No Charge
D0270	Bitewing - single film	No Charge

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ADA Code**	Service Description**	Member Copayment
D0272	Bitewings - two films‡ (once in any 6 calendar months)	No Charge
D0274	Bitewings - four films‡ (once in any 6 calendar months)	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0330	Panoramic film‡ (once in any 3 calendar years)	5.00
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - adult (once in any 6 calendar months)	5.00
D1120	Prophylaxis - child (once in any 6 calendar months)	5.00
D1203	Topical application of fluoride - child	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	15.00
D1510	Space maintainer - fixed - unilateral*	70.00
D1515	Space maintainer - fixed - bilateral*	70.00
D1520	Space maintainer - removable - unilateral*	95.00
D1525	Space maintainer - removable - bilateral*	115.00
D1550	Re-cementation of space maintainer	15.00
None	Additional prophylaxis (D1110 or D1120 service does not apply to patients with periodontal disease)***	30.00
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	15.00
D2150	Amalgam - two surfaces, primary or permanent	20.00
D2160	Amalgam - three surfaces, primary or permanent	30.00
D2161	Amalgam - four or more surfaces, primary or permanent	45.00
D2330	Resin-based composite - one surface, anterior	40.00
D2331	Resin-based composite - two surfaces, anterior	50.00
D2332	Resin-based composite - three surfaces, anterior	70.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	90.00
D2391	Resin-based composite - one surface, posterior	80.00
D2392	Resin-based composite - two surfaces, posterior	90.00
D2393	Resin-based composite - three surfaces, posterior	100.00
D2394	Resin-based composite - four or more surfaces, posterior	130.00
D2510	Inlay - metallic - one surface*	155.00
D2520	Inlay - metallic - two surfaces*	160.00
D2530	Inlay - metallic - three or more surfaces*	225.00
D2542	Onlay - metallic - two surfaces*	215.00
D2543	Onlay - metallic - three surfaces*	225.00
D2544	Onlay - metallic - four or more surfaces*	225.00
D2610	Inlay - porcelain/ceramic one surface*	220.00
D2620	Inlay - porcelain/ceramic two surfaces*	230.00
D2630	Inlay - porcelain/ceramic three or more surfaces*	245.00
D2740	Crown - porcelain/ceramic substrate*	300.00
D2750	Crown - porcelain fused to high noble metal*	300.00
D2751	Crown - porcelain fused to predominantly base metal*	300.00
D2752	Crown - porcelain fused to noble metal*	300.00
D2790	Crown - full cast high noble metal*	300.00
D2791	Crown - full cast predominantly base metal*	300.00
D2792	Crown - full cast noble metal*	300.00
D2910	Recement inlay, onlay, or partial coverage restoration	15.00
D2920	Recement crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	100.00
D2940	Sedative filling	20.00
D2950	Core buildup, including any pins	85.00

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ADA Code**	Service Description**	Member Copayment
D2951	Pin retention - per tooth, in addition to restoration	20.00
D2952	Post and core in addition to crown, indirectly fabricated*	110.00
D2954	Prefabricated post and core in addition to crown	90.00
D2962	Labial veneer (porcelain laminate) - laboratory*	315.00
D2980	Crown repair, by report*	30.00
None	Temporary filling***	20.00
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	20.00
D3120	Pulp cap - indirect (excluding final restoration)	20.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	50.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	100.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	190.00
D3330	Endodontic therapy, molar (excluding final restoration)	200.00
D3346	Retreatment of previous root canal therapy - anterior	340.00
D3347	Retreatment of previous root canal therapy - bicuspid	405.00
D3348	Retreatment of previous root canal therapy - molar	490.00
D3410	Apicoectomy/periradicular surgery - anterior	155.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	200.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	300.00
D3426	Apicoectomy/periradicular surgery - (each additional root)	115.00
D3430	Retrograde filling - per root	55.00
D3450	Root amputation - per root	125.00
D3920	Hemisection (including any root removal), not including root canal therapy	95.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	150.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	75.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	170.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	130.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	425.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	246.00
D4320	Provisional splinting - intracoronal	165.00
D4321	Provisional splinting - extracoronal	145.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	55.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	33.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	65.00
D4910	Periodontal maintenance	55.00
None	Periodontal hygiene instructions***	5.00
	Prosthodontics, removable	
D5110	Complete denture - maxillary*	335.00
D5120	Complete denture - mandibular*	335.00
D5130	Immediate denture - maxillary*	450.00
D5140	Immediate denture - mandibular*	450.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*	390.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	390.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	425.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	425.00
D5410	Adjust complete denture - maxillary	15.00
D5411	Adjust complete denture - mandibular	15.00
D5421	Adjust partial denture - maxillary	15.00
D5422	Adjust partial denture - mandibular	15.00
D5510	Repair broken complete denture base*	50.00
D5610	Repair resin denture base*	55.00
D5620	Repair cast framework*	55.00
D5630	Repair or replace broken clasp*	55.00
D5640	Replace broken teeth - per tooth*	55.00

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ADA Code**	Service Description**	Member Copayment
D5650	Add tooth to existing partial denture*	55.00
D5730	Reline complete maxillary denture (chairside)	60.00
D5731	Reline complete mandibular denture (chairside)	60.00
D5740	Reline maxillary partial denture (chairside)	60.00
D5741	Reline mandibular partial denture (chairside)	60.00
D5750	Reline complete maxillary denture (laboratory)*	100.00
D5751	Reline complete mandibular denture (laboratory)*	100.00
D5760	Reline maxillary partial denture (laboratory)*	100.00
D5761	Reline mandibular partial denture (laboratory)*	100.00
D5850	Tissue conditioning, maxillary	30.00
D5851	Tissue conditioning, mandibular	30.00
D5862	Precision attachment, by report*	160.00
	Prosthodontics, fixed	
D6210	Pontic - cast high noble metal*	300.00
D6211	Pontic - cast predominantly base metal*	300.00
D6212	Pontic - cast noble metal*	300.00
D6240	Pontic - porcelain fused to high noble metal*	300.00
D6241	Pontic - porcelain fused to predominantly base metal*	300.00
D6242	Pontic - porcelain fused to noble metal*	300.00
D6251	Pontic - resin with predominantly base metal*	300.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	165.00
D6721	Crown - resin with predominantly base metal*	300.00
D6750	Crown - porcelain fused to high noble metal*	300.00
D6751	Crown - porcelain fused to predominantly base metal*	300.00
D6752	Crown - porcelain fused to noble metal*	300.00
D6780	Crown - 3/4 cast high noble metal*	300.00
D6790	Crown - full cast high noble metal*	300.00
D6791	Crown - full cast predominantly base metal*	300.00
D6792	Crown - full cast noble metal*	300.00
D6930	Recement fixed partial denture	15.00
D6940	Stress breaker	150.00
D6950	Precision attachment	230.00
D6980	Fixed partial denture repair, by report*	55.00
None	Resin bonded bridge pontic, per unit***(*)	245.00
	Oral Surgery	
D7111	Extraction, coronal remnants - deciduous tooth	20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	60.00
D7220	Removal of impacted tooth - soft tissue	75.00
D7230	Removal of impacted tooth - partially bony	100.00
D7240	Removal of impacted tooth - completely bony	140.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	170.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	65.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	145.00
D7280	Surgical access of an unerupted tooth	115.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	75.00
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant	140.00
D7510	Incision and drainage of abscess - intraoral soft tissue	65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	150.00
	Other Services	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	25.00
D9220	Deep sedation/general anesthesia - first 30 minutes	180.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	175.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	40.00
D9940	Occlusal guard, by report*	90.00
D9951	Occlusal adjustment - limited	40.00
D9952	Occlusal adjustment - complete	165.00

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ADA Code**	Service Description**	Member Copayment
	Bleaching	
D9972	External bleaching - per arch	175.00

This is a sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage, and Copayment Schedule, which determine all rights, benefits, and applicable limitations and exclusions.

Listed copayments apply only to Plan Dentists who perform the corresponding listed services. The Plan Dentist selected by the Member may not perform all listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of Plan Dentists and Plan Specialty Dentists are subject to change.

** Current and prior versions of the Current Dental Terminology (CDT) codes (in the **ADA Code** column) and descriptors (in the **Service Description** column) are copyrighted by the American Dental Association (ADA) and are used by permission. *Current Dental Terminology* © American Dental Association.

*** Service does not have an American Dental Association Current Dental Terminology code or descriptor.

‡More often if medically necessary as determined by attending Plan Dentist.

Specialty Benefit

Copayment Schedule for the Heritage Series

How Your Specialty Benefit (SB) Works

Should you need the services of a specialty dentist, you may receive those services without a referral from your Plan Dentist.

To find a Plan Specialty Dentist (SB or Non-SB), refer to the provider directory. SB Plan Specialty Dentists are indicated with "SB". All other listed specialists are Non-SB Plan Specialty Dentists. Or, you may visit the web site at www.assurantemployeebenefits.com (click on Provider Search, and then on Heritage Series). For more information about the SB plan or for assistance in finding a Plan Specialty Dentist, call Customer Service at 800.443.2995.

If you use an SB Plan Specialty Dentist (a specialty dentist who is a part of the plan provider network and accepts SB copayments) for a service listed on the schedule below, you will pay the corresponding Member Copayment shown in the "**SB Specialty Dentist Copayment**" column at the time of service.

All **other** services obtained from an SB Plan Specialty Dentist, and **all** services obtained from a Non-SB Plan Specialty Dentist (a specialty dentist who is a part of the plan provider network but does **not** accept SB copayments), will be provided to you at a reduction in that Plan Specialty Dentist's normal retail charges. A 15% reduction applies if that dentist's specialty is endodontics. A 25% reduction applies if that dentist has any other type of specialty, including but not limited to orthodontics. You will be responsible for paying the entire reduced charge at the time of service or in accordance with that Plan Specialty Dentist's billing procedures.

If you choose to go to a Non-Plan Specialty Dentist (a specialty dentist who is **not** part of the plan provider network), you may still receive benefits!

If you obtain a service listed on the schedule below from a Non-Plan Specialty Dentist, you will be responsible for paying that specialty dentist's entire normal retail charge for the service at the time of service or in accordance with that specialty dentist's billing procedures. You may then submit a completed claim form, with an itemized bill attached to United Dental Care of Texas, Inc. (You may obtain claim forms by contacting Customer Service at 800.443.2995.) United Dental Care of Texas, Inc. will reimburse you the lesser of (a) the corresponding amount shown in the **"Maximum Reimbursement with a Non-Plan Specialty Dentist"** column of the schedule below or (b) the amount charged by that specialty dentist for service.

Payment for any **other** service of a Non-Plan Specialty Dentist, at that specialty dentist's normal retail charge, is your responsibility, except for Plan Benefits for covered dental Emergency Services.

Annual Maximum Benefit

There is no annual maximum benefit for services of an SB or Non-SB Plan Specialty Dentist. For services of a Non-Plan Specialty Dentist, there is a $2,000 annual maximum benefit.

ADA Code**	Service Description**	SB Plan Specialty Dentist Copayment	Maximum Reimbursement with A Non-Plan Specialty Dentist
	Appointments		
D0140	Limited oral evaluation - problem focused	35.00	20.00
D0150	Comprehensive oral evaluation - new or established patient‡ (once in any 6 calendar months) (may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	45.00	25.00
D0160	Detailed and extensive oral evaluation - problem focused, by report	67.00	45.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	35.00	25.00
D0180	Comprehensive periodontal evaluation - new or established patient	80.00	50.00
	Endodontics		
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	280.00	320.00
D3330	Endodontic therapy, molar (excluding final restoration)	395.00	405.00

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ADA Code**	Service Description**	SB Plan Specialty Dentist Copayment	Maximum Reimbursement with A Non-Plan Specialty Dentist
D3346	Retreatment of previous root canal therapy - anterior	360.00	230.00
D3347	Retreatment of previous root canal therapy - bicuspid	525.00	265.00
D3348	Retreatment of previous root canal therapy - molar	545.00	345.00
D3410	Apicoectomy/periradicular surgery - anterior	265.00	335.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	280.00	420.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	310.00	390.00
D3430	Retrograde filling - per root	90.00	85.00
	Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	355.00	195.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	100.00	65.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	495.00	395.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	215.00	170.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	100.00	90.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	70.00	65.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	80.00	50.00
	Oral Surgery		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80.00	120.00
D7220	Removal of impacted tooth - soft tissue	105.00	125.00
D7230	Removal of impacted tooth - partially bony	135.00	155.00
D7240	Removal of impacted tooth - completely bony	200.00	130.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	220.00	180.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	75.00	125.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	180.00	70.00
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant	130.00	150.00
D7510	Incision and drainage of abscess - intraoral soft tissue	105.00	55.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	185.00	145.00
	Other Services		
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	170.00	115.00

This is a sample schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage, and Copayment Schedule, which determine all rights, benefits, and applicable limitations and exclusions.

Listed copayments apply only to SB Specialty Dentists who perform the corresponding listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of SB and Non-SB Plan Specialty Dentists are subject to change.

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‡More often if medically necessary as determined by attending Plan Dentist.

Learn more about the prepaid dental plan being offered to you!

Your employer is offering you an attractive prepaid dental plan. This Q&A will help provide you more information about the plan being offered to you.

What is a prepaid plan?

With a prepaid plan you pay a monthly prepayment fee plus you pay reduced fees called "copayments" for dental services provided. To receive the reduced fees you must use a Plan Dentist selected at the time of enrollment.

What are copayments and where can I locate the copayment schedule?

A copayment is the set fee that you pay to the Plan Dentist at the time of treatment for covered services that are being performed.

The copayment schedule is a listing of covered services and copayments for your plan. The schedule is included in the Evidence of Coverage. It is helpful to bring your copayment schedule to your dental appointment.

How do I select a Plan Dentist?

You should select your Plan Dentist when you enroll. You can visit www.assurantemployeebenefits.com and go to Provider Search or refer to your plan network directory for a listing of Plan Dentists. On the web site please choose the Heritage Series network listed on the Provider Search page for provider look-up. Note that your Plan Dentist must be a general dentist, not a specialty dentist.

How long does it take to appear on the patient list/roster of my Plan Dentist that I select at time of enrollment?

If we receive your Plan Dentist selection by the 20th of the month, you will appear on the roster the 1st of the next month. If we receive the selection after the 20th, you will appear on the roster the 1st day of the second following month. If you are not listed on the roster, please contact us at 800.443.2995.

How will the Plan Dentist know I am a patient?

The Plan Dentist receives a patient listing, called a roster, from us each month that includes all members who have chosen that individual as their dentist.

Please confirm at the time of making your appointment with the Plan Dentist that you are on the provider's roster.

Can I change my Plan Dentist?

Yes, you can. To change your Plan Dentist, contact Customer Service at 800.443.2995.

What if I choose to see a dentist other than my selected Plan Dentist?

The costs will **not** be covered by your dental plan and you will be responsible for the full payment to the dentist. This is why it is important for you to seek treatment from your selected Plan Dentist.

If I have a dental emergency, do I need to see my Plan Dentist?

First, contact your Plan Dentist to make an appointment. If your Plan Dentist is unable to see you, you may seek treatment from any licensed dentist in the United States.

Please be informed that the emergency benefit in your plan only covers procedures administered in a dentist's office or comparable facility to evaluate and stabilize conditions that are Dental Emergencies, as specified (with a description of benefits payable) in the Evidence of Coverage.

If I need to see a specialty dentist, how do I go about finding a Plan Specialty Dentist in my area?

You may find a list of Plan Specialty Dentists by looking in the plan network directory, visiting the web site at www.assurantemployeebenefits.com or calling 800.443.2995 for assistance. No referrals are necessary from your Plan Dentist to seek treatment from a Plan Specialty Dentist.

What if I lose my Dental ID card or have a question about my plan?

Contact Customer Service by calling 800.443.2995.

Pre-existing Conditions

Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether or not such conditions existed before the effective date of the Member's enrollment.

Limitations and Exclusions

Plan Benefits are not available for:

1. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service).
2. Any part of and dental service for which a charge is incurred before the effective date of the Member's enrollment.
3. Any dental service initiated after the Member's enrollment ends.
4. Services provided by Non-Plan Providers unless (a) for services of Non-Plan Specialty Dentists as specifically provided in the SPECIALTY DENTIST SERVICES section of the Copayment Schedule or (b) for Emergency Services as specifically provided in the EMERGENCY PROCEDURES Article of the Evidence of Coverage.
5. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five years have elapsed since such appliance was provided as a Plan Benefit, or (b) during that five-year period, appliance becomes unusable and cannot be made usable due to the Member's illness or an accident involving damage to the appliance while it is in use.
6. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.
7. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan).
8. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.
9. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.
10. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
11. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.
12. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
13. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.
14. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

Orthodontic Extractions

Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.

Termination

The Member's enrollment may be terminated as stated in the **TERMINATION** article of the Evidence of Coverage.

GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name **DEERPARK, CITY OF (PLAN C300)**	Group Number	Effective Date / /

❑ **I apply for the following coverage for myself and dependents, as listed.**

HMO Plan

❑ **Secure**

Employee First Name	MI	Last Name	❑ M ❑ F	Date of Birth / /	**Facility ID #**
Employee Street Address	City	State Zip		Employee Social Security Number	
Home Phone ( )	Work Phone ( )	Division/Department/Class			Date of Hire / /

Dependents to be included for coverage:

First Name	MI	Last Name (if different)	Relationship	Sex	Date of Birth	**Facility ID#**
Spouse				❑ M ❑ F	/ /	
Child(ren)				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	

Check any boxes that apply and follow instructions.

❑ Are you covering more than three children? **Please continue listing on additional Enrollment Forms.**

❑ Is the address of any child different than the member's? **Show that child's name & address on the back of this form.**

❑ Are you requesting coverage for a dependent child other than a son or daughter? **Forward legal custody paper.**

❑ Are you requesting coverage for dependent child over age 25? **Furnish proof of incapacity within 31 days of the Effective Date.**

❑ Check this box if you have a disability affecting your ability to communicate or read.

Please indicate your primary language by placing a check in the appropriate box: ❑ English ❑ Spanish ❑ Other

❑ **I elect not to have coverage for myself or my dependents and I hereby waive coverage under the above mentioned plans.**

Signature:_____ **Date:**_____

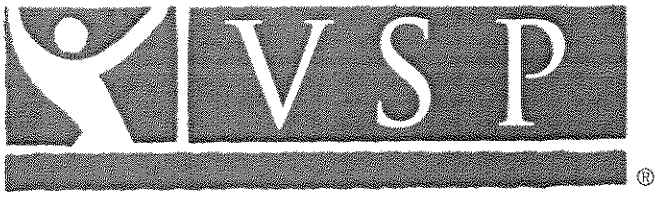
To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any coverage. Please read the following and sign below.

The HMO Plan is provided by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company.

I hereby apply for membership in this dental Plan for myself and for any eligible dependents listed above. I authorize the Group named above to make deductions, if any, required as my contribution. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Plan and the terms and conditions of the Group Dental Service Agreement. I authorize any licensed dentist, physician, hospital or other health care provider to furnish United Dental Care of Texas, Inc., Union Security Insurance Company, and their affiliated dental companies with any required dental or medical information, as permitted by law about myself and any eligible dependents listed. I represent the information provided is true and correct to the best of my knowledge. I further understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I will promptly advise the Plan and my Group of any changes in this information. The authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing United Dental Care of Texas, Inc., Union Security Insurance Company, and their affiliated dental companies to use and disclose protected health information. **IMPORTANT WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of benefits.**

Signature:_____ **Date:**_____

Vision Discount Services



ACCESS PLAN

Your dental plan includes a vision discount plan through Vision Service Plan (VSP). The vision plan includes discounts on exams (including contact lens exams) and the purchase of eyeglasses, sunglasses and other prescription eyewear when provided by VSP doctors. VSP is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams** – 20% discount applied to VSP doctor's usual and customary fees for eye exams[1]
- **Glasses** – 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options[2]
- **Contact Lenses** – 15% discount off the contact lens exam (fitting and evaluation)[2].
- **Laser VisionCare**[SM] – VSP has contracted with many of the nation's laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out

How to Use VSP

Locate a VSP doctor near you. You may either use our Web-based doctor locator at www.vsp.com, or call VSP at 800.877.7195 to request a doctor listing.

Identify yourself as a VSP member and be prepared to provide the *enrolled member's* social security number when you make your appointment. (The VSP doctor will verify your eligibility and vision plan coverage, and will obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.

[1]Note: Does not apply to contact lens services. See contact lens section for applicable discount.
[2]Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

VSP Member Services Support: 800.877.7195
Visit our Web site at www.vsp.com

VSP